DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

12-30-17 / 1-2418 / 45th day / 70th day / 11-28-17

PRINTED: 11/28/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
POC #1	445256	A. BUILDING _____ B. WING _____	11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTSVILLE CONVALESCENT CENTER	649 MCMURRY BLVD HARTSVILLE, TN 37074

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification survey and complaint investigation #42720 were completed on 11/13/17/ - 11/15/17 at Hartsville Convalescent Center. No deficiencies were cited related to complaint investigation #42720. Deficiencies were for the Recertification survey under 42 CFR PART 483, Requirements for Long Term Care Facilities.	F 000		
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).	F 157	F 157 Our facility will inform the resident; consult with the resident's Dr; and notify, consistent with his/her authority, the resident representative(s) when there is- a. an accident involving the resident which results in injury and has the potential for requiring Dr. intervention; b. a significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); c. a need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or d. a decision to transfer or discharge the resident from the facility 483.15(c)(1)(ii) when making notification under (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in 483.15 ©(2) is available & provided upon request to the Dr. (iii) our facility must also promptly notify the resident and the resident representative, if any, when there is- a. a change in room or roommate assignment as specified in 483.10(e)(6); or b. a change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) the facility will record and periodically update the address (mailing & email) & phone number of the resident representative(s)	12-31-17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah Gusley — TITLE: Administrator — (X6) DATE: 12-6-17

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	Continued From page 1 (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to notify the Physician of recommendations for 1 resident (#5) of 26 residents reviewed. The findings included: Resident #5 was admitted to the facility on 4/7/04 and readmitted on 8/10/15 with diagnoses including Type I Diabetes Mellitus, Type II Diabetes Mellitus, Cataracts, Hypertension, Peripheral Vascular Disease, Edema, Arthropathy, Long Term Use of Insulin, Heart Failure, Atherosclerotic Heart Disease, Chronic Obstructive Pulmonary Disease, Bipolar Disorder, Moderate Intellectual Disabilities, Peptic Ulcer	F 157	F 157 1.The Dr. has been called regarding Resident #5's recommendations from Onsight Vision 2.The DON will develop a log to list the recommendations from the dental & vision consultants as well as putting in place a method of ensuring the follow thru with the recommendation has occurred 3. The licensed nursing staff will be in serviced regarding this process 4. The recommendations from the dental & vision consultants will be reviewed during the weekly QAPI/IDT meeting after each visit for 3 months to ensure timely follow through with any recommendations. Any adverse findings will be immediately addressed with appropriate interventions.	

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F 157	Continued From page 2 and Gastro-Esophageal Reflux Disease. Medcial record review of the Quarterly Minimum Data Set (MDS) dated 6/2/17 and 9/1/17 revealed Resident #5 had a Brief Interview for Mental Status score of 3, indicating severe cognitive impairment. Continued review of the MDS dated 6/2/17 and 9/1/17 revealed the resident had impaired vision and did not have corrective lenses. Medcal record review of the Care Plan for Resident #5 revealed the resident had visual deficits. Medical record review of a Request for an Eye Evaluation dated 6/13/17 revealed a request for an eye evaluation to be completed. Continued review of an eye exam evaluation completed on 6/30/17 revealed a recommendation for the resident to receive "...artificial tear tid [three times per day]...Daily activities and quality of life affected. Refer for Cataract evaluation..." Medical record review revealed no documetation the Physician had been notified of the recommendations nor had a cataract evaluation referral been made. Interview with Licensed Practical Nurse (LPN) #4 on 11/14/17 at 2:50 PM at the 2nd floor nurses station revealed if a referral was needed the Physician was notified and ordered the referral appointment. Interview with LPN #1 on 11/14/17 at 5:05 PM in the conference room revealed an eye exam evaluation went to the Director of Nursing (DON) and then to the floor nurse, who was responsible	F 157		

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F 157	Continued From page 3 for contacting the Physician to notify of recommendations. Continued interview revealed documentation of the Physician notification would be in the Nurse's Notes. LPN #1 reviewed Nurse Progress Notes and confirmed there was no documentation of notification to the Physician of the recommendations. LPN #1 confirmed the facility failed to notify the Physician of the eye exam recommendations for a cataract referral and artificial tears for Resident #5. Interview with the DON on 11/14/17 at 5:17 PM in the conference room confirmed the facility failed to ensure the Physician was notified of the eye exam recommendations for a cataract referral or the need for artificial tears for Resident #5.	F 157		
F 241 SS=E	DIGNITY AND RESPECT OF INDIVIDUALITY CFR(s): 483.10(a)(1) (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure dignity and respect for 5 of 11 residents observed during a meal. The findings included: Observation of a lunch meal on 11/13/17 between 12:20 PM and 12:40 PM in the 1st floor common area revealed Certified Nurse Aide (CNA) #1 completed tray set-up for 5 residents. Further observation revealed CNA #1 removed a	F 241		

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F 241	Continued From page 4 sandwich from a plastic bag with an ungloved hand and placed the sandwich on the tray for each resident. Continued observation revealed CNA #2 completed a tray set-up for 1 resident. Further observation revealed CNA #2 removed a sandwich from a plastic bag with an ungloved hand and placed it on the tray. Interview with CNA #1 on 11/13/17 at 12:45 PM at the 1st floor nurses station revealed she always removes the sandwiches from the bag with an ungloved hand. Continued interview revealed sometimes sandwiches were served on plates and sometimes they were not. Interview with CNA #2 on 11/13/17 at 2:45 PM at the 1st floor nurses station revealed when completing tray set up for a resident she normally removed the sandwich with an ungloved hand and placed it on the tray. Further interview revealed sandwiches were not always served on a plate. Interview with the Director of Nursing (DON) on 11/13/17 at 6:05 PM in her office revealed she expected staff to wear gloves if they have to touch resident food. Continued interview revealed the DON expected plates to be provided for food to be placed on. After informing the DON of the lunch observation the DON stated the CNAs were not to touch resident food with ungloved hands and were not to place food items on the tray. The DON confirmed the facility failed to ensure dignity and respect for 5 residents during a meal. Interview with the Administrator on 11/14/17 at 7:38 AM in her office revealed she expected all food to be served on plates. After informing the Administrator of the lunch observation the	F 241	F 241 We will treat & care for each resident in a manner & in an environment that promotes maintenance or enhancement of his/her quality of life recognizing each resident's individuality. Our facility will protect & promote the rights of The resident. 1.CNA's will be in-serviced on the appropriate way to set up a resident's tray & instructed they must always wear gloves if they touch any food items on a resident's tray. 2.The dietary manager has been instructed sandwiches must always be served on a plate. The dietary department will be in-serviced on the appropriate way sandwiches should be served. 3.Meal times will be monitored by nursing managers, department managers including the administrator and DON for 1 month, then managers will be given specific meal times & days they will have dining room duty. 4.The findings during the meal time monitoring will Be reviewed during the weekly QAPI/IDT meeting for 1month with interventions as needed.	12-31-17

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F 241	Continued From page 5 Administrator stated "...that was completely inappropriate..." The Administrator confirmed the facility failed to ensure dignity and respect for 5 residents during a meal.	F 241		
F 252 SS=E	SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT CFR(s): 483.10(e)(2)(i)(1)(I)(Ii) (e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. §483.10(i) Safe environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- (i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. This REQUIREMENT is not met as evidenced by: Based upon observation and interview, the facility failed to provide a home like environment for 1 of 2 meals observed.	F 252	F 252 The resident has the right to retain & use personal possessions, including furnishings, & clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents. The resident has a right to a safe, clean comfortable, And homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility will provide- A safe, clean, comfortable, & homelike environment, allowing the resident to use his/her personal belongings to the extent possible. This includes ensuring the resident can receive care and services safely & that the physical layout of the facility maximizes resident independence & does not pose a safety risk. The facility will exercise reasonable care for the protection of the resident's property from loss or theft. 1.CNA's will be in-serviced on the appropriate way to set up the resident's tray and instructed to never handle any resident's food without using the appropriate gloves. 2.The dietary manager has been instructed to always serve sandwiched on an appropriate plate. The dietary staff will be in-serviced on the appropriate way sandwiches should be served. 3.Meal times will be monitored by nursing managers, department managers including the administrator & DON. 4.The findings during the meal time monitoring will be reviewed during the weekly QAPI/IDT meeting for 1 month with interventions as needed.	12-31-17

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F 252	Continued From page 6 The findings included: Observation of a lunch meal on 11/13/17 between 12:20 PM and 12:40 PM in the 1st floor common area revealed Certified Nurse Aide (CNA) #1 completed tray set-up for 5 residents. Further observation revealed CNA #1 removed a sandwich from a plastic bag with an ungloved hand and placed the sandwich on a tray for each resident. Continued observation revealed CNA #2 completed a tray set-up for 1 resident. Further observation revealed CNA #2 removed a sandwich from a plastic bag with an ungloved hand and placed it on the tray. Interview with CNA #1 on 11/13/17 at 12:45 PM at the 1st floor nurses station revealed she always removed the sandwiches from the bag with an ungloved hand. Continued interview revealed sometimes sandwiches were served on plates and sometimes they were not. Interview with CNA #2 on 11/13/17 at 2:45 PM at the 1st floor nurses station revealed when completing tray set-up for a resident she normally removed the sandwich with an ungloved hand and placed it on the tray. Further interview revealed sandwiches were not always served on a plate. Interview with the Director of Nursing (DON) on 11/13/17 at 6:05 PM in her office revealed she expected staff to wear gloves if they have to touch resident food. Continued interview revealed the DON expected plates to be provided for food to be placed on. After informing the DON of the lunch observation the DON stated the CNAs were not to touch resident food with ungloved hands and were not to place food items on the tray. The	F 252		

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F 252	Continued From page 7 DON confirmed the facility failed to provide a home like environment during a meal. Interview with the Administrator on 11/14/17 at 7:38 AM in her office revealed she expected all food to be served on plates. After informing the Administrator of the lunch observation the Administrator stated "...that was completely inappropriate..." The Administrator confirmed the facility failed to provide a home like environment during a meal.	F 252		
F 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.21(b)(3)(ii) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility failed to ensure a follow-up appointment was obtained for 1 resident (#5) of 26 residents reviewed. The findings included: Resident #5 was admitted to the facility on 4/7/04 and readmitted 8/10/15 with diagnoses including Type I Diabetes Mellitus, Type II Diabetes Mellitus, Cataracts, Hypertension, Peripheral Vascular Disease, Edema, Arthropathy, Long Term Use of Insulin, Heart Failure,	F 282		

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F 282	Continued From page 8 Atherosclerotic Heart Disease, Chronic Obstructive Pulmonary Disease, Bipolar Disorder, Moderate Intellectual Disabilities, Peptic Ulcer, and Gastro-Esophageal Reflux Disease. Medical record review of the Quarterly Minimum Data Set (MDS) dated 6/2/17 and 9/1/17 revealed the resident had impaired vision and did not have corrective lenses. Medical record review of the Care Plan for Resident #5 revealed the resident had visual deficits. Medical record review of a Request for an Eye Evaluation dated 6/13/17 revealed a request for eye evaluation to be completed. Continued review of an eye exam evaluation dated 6/30/17 revealed it was recommended for the resident to receive "...artificial tear tid [three times per day]...Daily activities and quality of life affected. Refer for Cataract evaluation..." Medical record review revealed the Physician had not been notified of the recommendations nor had a cataract evaluation referral been made. Interview with Licensed Practical Nurse (LPN) #4 on 11/14/17 at 2:50 PM at the 2nd floor nurses station revealed if a referral was needed the Physician was notified and ordered the referral appointment. LPN #4 stated the nurse was responsible for making the referral appointment once ordered by the physician. Interview with LPN #1 on 11/14/17 at 5:05 PM in the conference room revealed eye exam evaluation went to the Director of Nursing (DON) and then to the floor nurse, who was responsible	F 282	F 282 The services provided or arranged by the facility, as outlined by the comprehensive care plan, will - be provided by qualified person in accordance with each resident's written plan of care. 1.The recommendations made for any eye exams and/or surgeries will be logged by the DON before giving to the nurse to notify the attending & include in the nurses notes. 2. The DON will follow up from her log within an appropriate time frame to see that the recommendations have been followed through with 3.The DON will bring her findings to the weekly QAPI/IDT weekly meetings 4. The recommendations after the eye clinic visits will be reviewed during the weekly QAPI/IDT meeting to ensure interventions were processed appropriately for 3 of the eye clinic visits	12-31-17

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F 282	Continued From page 9 for contacting the Physician to notify of recommendations. Continued interview revealed notification to the Physician would be in the Nurse's Notes. LPN #1 reviewed Nurse Progress Notes and confirmed there was no documentation of the Physician being notified of the recommendations. LPN #1 confirmed the facility failed to notify the physician of the eye exam recommendations for a cataract referral and artificial tears for Resident #5. Interview with the DON on 11/14/17 at 5:17 PM in the conference room confirmed the facility failed to ensure the Physician was notified of the eye exam recommendations for a cataract referral or the need for artificial tears for Resident #5.	F 282		
F 371 SS=F	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food	F 371		

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F 371	Continued From page 10 service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to serve sandwiches on plates to residents; failed to serve lemon squares on plates to the residents; failed to wash or sanitize hands prior to donning gloves and serving food; failed to remove contaminated gloves prior to handling bulk food; failed to thoroughly dry plate lids prior to use; failed to maintain a clean and sanitary ice machine and nourishment refrigerator; failed to dispose of expired buttermilk, and failed to date applesauce and sandwiches available for resident use. The findings included: Observation of a lunch meal on 11/13/17 between 12:20 and 12:40 PM in the 1st floor common area revealed Certified Nurse Aide (CNA) #1 completed tray set up for 4 residents. Further review revealed CNA #1 removed the sandwich from the plastic bag with an ungloved hand and placed the sandwich on the tray for each resident. Continued review revealed CNA #2 completed the tray set up for 1 resident. Further review revealed CNA #2 removed the sandwich from a plastic bag with an ungloved hand and placed it on the tray. Interview with CNA #1 on 11/13/17 at 12:45 PM at the 1st floor nurses station revealed she always removed the sandwiches from the bag with an ungloved hand. Continued interview revealed	F 371	F 371 (i)(1) Facility will procure food from sources approved or considered satisfactory by federal, state or local authorities. This may include food items obtained directly from local producers, subject to applicable State & local laws or regulations. This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subjected to compliance with applicable sales growing & food handling practices. This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) Store, prepare, distribute and serve food in service safety. (i)(3) Have a policy regarding use & storage of Foods brought to residents by family & other visitors to ensure safe & sanitary storage, handling, & consumption. 1.CNA's will be in serviced on the appropriate way to set up a resident's tray & instructed they should always wear gloves if they touch any food item on the resident's tray. 2.Dietary staff will be in-serviced on handwashing Requirements. 3.Dietary staff will be in-serviced on the correct way to dry & stack plate lids & bowls which allows appropriate drying. 4.The ice machines were cleaned the day of adverse findings. The ice machines are to be locked at all times to avoid residents from opening the machine. Staff will be in-serviced on ensuring the ice machines are kept locked at all times. The HK supervisor now has the ice machines on a routine cleaning/ sanitizing schedule.	12-31-17

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	445256	A. BUILDING _____ B. WING _____	11/15/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARTSVILLE CONVALESCENT CENTER	649 MCMURRY BLVD HARTSVILLE, TN 37074

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F 371	Continued From page 11 sometimes sandwiches were served on plates and sometimes they were not. Interview with CNA #2 on 11/13/17 at 2:45 PM at the 1st floor nurses station revealed when completing tray set up for a resident she normally removed the sandwich with an ungloved hand and placed it on the tray. Further interview revealed sandwiches were not always served on plates. Observation of a dinner meal on 11/13/17 between 5:25 PM and 5:45 PM in the 1st floor common area revealed 6 residents were served desert squares in plastic bags without plates. Interview with the Director of Nursing (DON) on 11/13/17 at 6:05 PM in her office revealed she expected staff to wear gloves if they have to touch resident food. Continued interview revealed the DON expected plates to be provided for food to be placed on. After informing the DON of the lunch and dinner observation the DON stated the CNAs were not to touch resident food with ungloved hands and were not to place food items on the tray. The DON confirmed the facility failed to distribute food in a sanitary manner. Interview with the Administrator on 11/14/17 at 7:38 AM in her office revealed she expected all food to be served on plates. After informing the Administrator of the lunch and dinner observation the Administrator stated "...that was completely inappropriate..." The Administrator confirmed the facility failed to serve food in a sanitary manner. Observation on 11/13/17 at 5:28 PM in the Dietary Department revealed the Cook and Dietary Aide #1 delivered a dining cart and a hall	F 371	F 371 5. The refrigerator in the nourishment room has since been cleaned. The buttermilk, applesauce & peanut butter sandwiches have been discarded. The nursing department will be responsible for cleaning the refrigerator & will be in-serviced on their responsibility for cleaning the refrigerator & monitoring the dates on the resident's snacks that are sent out. The dietary department will be reminded in an in-service that all items going out to the nourishment rooms must be dated. The nursing & administrative management staff will monitor the dining delivery service to residents for 1 month to ensure the staff are using appropriate methods when setting up residents' trays for their meals. Any adverse findings will be addressed/corrected immediately. The dietary manager will monitor her staff for 1 month to ensure they are following appropriate handwashing techniques & appropriate frying techniques for plates, lids, etc. Any adverse findings will be addressed/corrected immediately. Their findings will be reviewed by the QAPI/IDT weekly meeting for 1 month.	

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OMB NO. 0938-0391

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371	Continued From page 12 cart to the downstairs dining room and the E and F hall. Continued observation revealed they returned to the Dietary Department at 5:33 PM and failed to wash or sanitize their hands prior to donning gloves and plating food and drinks from the beverage area and steam table. Further observation revealed the Dietary Aide used her gloved hand to open the reach in cooler and obtained bulk sliced cheese. Continued observation revealed she touched multiple slices of the bulk cheese with her left gloved hand while pulling a piece of sliced cheese with the right gloved hand; then lifted a slice of bread from a bologna sandwich; placed the cheese on the bologna; put the bread back on top; and placed the sandwich on a plate. Interview with the Cook and Dietary Aide #1 on 11/13/17 at 5:50 PM in the Dietary Department confirmed they failed to wash or sanitize their hands prior to donning gloves and serving beverages and food for the residents. Further interview with the Dietary Aide confirmed she failed to remove contaminated gloves and wash her hands prior to handling bulk cheese and bread for resident use. Observation on 11/14/17 at 1:45 PM in the Dietary Department with the Dietary Manager (DM) present revealed 9 plate lids stacked on the prep table and used during the lunch meal. Continued observation revealed the inside of the lids were not dry. Continued observation revealed 1 rack of plate lids were stacked against one another and placed on the drying rack immediately after washing and rinsing without air drying. Continued observation revealed soup bowls were placed on top of each other and were not allowed to air dry completely.	F 371		

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F 371	Continued From page 13 Interview with the DM on 11/14/17 at 1:48 PM in the Dietary Department confirmed the facility failed to provide adequate space or drying racks to air dry dishes completely prior to resident use. Observation of the ice machine on C Hall on 11/14/17 at 2:15 PM with the DM present revealed pink shiny debris on the inside top of the ice machine. Further observation of the nourishment refrigerator on the F hall at 2:40 PM with the DM present revealed greenish/black debris on the refrigerator and freezer seal. Continued observation revealed orange shiny debris on the middle glass shelf of the refrigerator along with food items available for resident use. Interview with the DM on 11/14/17 at 2:45 PM in the F hall nourishment room confirmed the facility failed to maintain a clean and sanitary ice machine and nourishment refrigerator for the residents. Observation of the nourishment refrigerator on E hall on 11/14/17 at 2:30 PM with the DM present revealed two 8 ounce cartons of buttermilk dated 11/13/17; one 4 ounce soufflé cup of applesauce undated; and four and one half peanut butter sandwiches undated available for resident use. Interview with the DM on 11/14/17 at 2:33 PM in the E hall nourishment room confirmed the facility failed to dispose of expired buttermilk and failed to date applesauce and peanut butter sandwiches available for resident use.	F 371		
F 515 SS=F	RETENTION OF RESIDENT CLINICAL RECORDS CFR(s): 483.70(i)(4)(i)-(iii)	F 515		

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F 515	Continued From page 14 (i) Medical records. (4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. This REQUIREMENT is not met as evidenced by: Based on review of facility policy, medical record review, and interview, the facility failed to maintain resident clinical records for the appropriate time frame. The findings included: Review of facility policy, ADL (Activities of Daily Living) Flow Sheets, dated 1/15/16 revealed "...ADL flowsheets are collected by the DON [Director of Nursing] at the end of each month, and kept in the DON office for 30 days. At the end of the 30 day period, all flow sheets are shredded and a new 30 day collected..." Resident #5 was admitted to the facility on 4/7/04 and readmitted 8/10/15 with diagnoses including Type I Diabetes Mellitus, Type II Diabetes Mellitus, Cataracts, Hypertension, Peripheral Vascular Disease, Edema, Arthropathy, Long Term Use of Insulin, Heart Failure, Atherosclerotic Heart Disease, Chronic Obstructive Pulmonary Disease, Bipolar Disorder, Moderate Intellectual Disabilities, Peptic Ulcer, and Gastro-Esophageal Reflux Disease.	F 515	F 515 Medical records will be retained for the period of time required by State law; or five years from the date of discharge when there is no requirement in State law; or for a minor, 3 years after a resident reaches legal age under State law. 1.The facility ADL flow sheets policy will be changed from retaining the flow sheets for 30 days to retaining the flow sheets for 3 months (90 days). 2.The nursing staff will be in-serviced on changing the ADL flow sheets retention time 3.The DON & MDS coordinator will monitor the ADL flow sheet time frame retention change to ensure the look-back time for completing the MDS process is sufficient. if not sufficient, the retention time will be changed 4.The change in retaining the ADL flow sheets will be reviewed after the 90-day retention change to ensure the look-back time frame supports an appropriate look-back time for the MDS process	12-31-17

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F 515	Continued From page 15 Review of the Quarterly Minimum Data Set (MDS) dated 6/2/17 revealed Resident #5 had a Brief Interview for Mental Status score of 3, indicating severe cognitive impairment. Resident #5 required supervision for transferring, walking in room/corridor, locomotion on/off unit, eating; required extensive assistance with dressing, toileting and Activities of Daily Living (ADLs) and utlized a walker. Review of the Quarterly MDS dated 9/1/17 revealed the resident had impaired vision and did not have corrective lenses. Resident #5 required limited assistance for bed mobility and eating; required supervision to walk in room/corridor and utilized a walker, locomotion on/off unit, transfers and dressing; required extensive asssistance for toileting and ADLs. Medical record reveiw revealed there were no ADL flowsheets for the months prior to October 2017. Interview with the DON on 11/14/17 at 3:05 PM at the 2nd floor nurses station revealed the facility destroyed the ADL Flowsheets once the MDS Coordinator obtained the information needed for the MDS review after 30 days. Interview with Licensed Practical Nurse #2 on 11/14/17 at 4:25 PM at the 2nd floor nurses station revealed she utilized the ADL flowsheets to complete the MDS. Interview with the Administrator on 11/15/17 at 5:25 PM in her office revealed the facility destroyed the ADL flowsheets after 30 days and confirmed the facility failed to maintain resident clinical records for the appropriate time frame.	F 515		